RSA DDR (01/12)

Direct Deposit Authorization
Retirement Systems of Alabama

P.O. Box 302150
Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
www.rsa-al.gov

The retiree or beneficiary of a deceased retiree must complete the front page of this form. Then take or mail the form to your financial institution so they may verify the information on the front, **complete the information on the reverse side**, and agree to the Master Agreement.

Benefit Recipient Information

Social Security Number _____

Benefit Recipient (Please check one):
- ☐ **Retiree**
- ☐ **Beneficiary of Deceased Retiree/Member**

Name _____

Address _____

_____

_____

Daytime Phone No. _____

Email Address _____

Indicate the system(s) from which you would like your benefit(s) direct deposited.

☐ Teachers' Retirement System ☐ Employees' Retirement System ☐ PEIRAF ☐ Judicial Retirement Fund

☐ RSA-1 *(Annual of Monthly Distribution Only)*

Joint Financial Institution Account Holder's Certification:

I agree to notify the Retirement Systems of Alabama (RSA) immediately of the death of the recipient of the retirement benefits being deposited to this joint financial institution account, and to return all payments to the RSA that are deposited to this account after said death. The RSA will determine and pay any survivor benefits. The RSA is authorized to make necessary debit entries to this joint financial institution account for any credits that were made in error.

Name(s) of Joint Financial Institution Account Holder(s)	Signature(s) of Joint Financial Institution Account Holder(s)
_____	_____
_____	_____
_____	_____

Date _____

Benefit Recipient Certification:

Each benefit payment is to be credited to my account at the financial institution specified on the reverse side of this form and such payment will be in full payment, satisfaction, and discharge of the amount then falling due and payable to me on account of such payments.

If my death occurs prior to the due date of any payment made by the RSA in compliance with this request or if adjustments are required for any credit entries to my account, I authorize the RSA to make the necessary debit entries to my account. I hereby reserve the right to revoke or cancel this request, such revocation or cancellation to take effect within 30 days of receipt of written notice by the RSA.

I authorize my payment to be sent to the financial institution named on the reverse side of this form to be deposited to the designated account.

Signature of Benefit Recipient _____ Date _____

Financial Institution Information (to be completed by a representative of the financial institution)

Name of Benefit Recipient _____ Soc. Sec. No. _____

Depositor Account No. _____ Bank Routing No. _____

Name of Financial Institution _____ Type of Account: ☐ Checking ☐ Savings

Mailing Address _____

_____

Name(s) of Person(s) on this Account: _____

_____

_____

Financial Institution Certification and MASTER AGREEMENT:

Both the Retirement Systems of Alabama (RSA), as Originator, and the above named Financial Institution identified on this side of the form consider the following to be the **MASTER AGREEMENT** pursuant to the provisions of Section 4.8.5 of the 2006 Operating Rules of the National Automated Clearing House Association and agree that it is to be applicable to all payments sent by the RSA to the Financial Institution for the benefit of all benefit recipients having accounts at the Financial Institution.

In consideration of the RSA making payments in accordance with the foregoing request without requiring proof that the retiree/beneficiary identified on this form is alive on the date which such payments become due and are credited to his or her account, the Financial Institution hereby agrees to repay and refund to the RSA on demand, the amount of any payments made to and received by the Financial Institution, the due date of which occurred after the date of death of the benefit recipient. The Financial Institution further agrees to accept the certification of the RSA as to the date of death of such payee as sufficient evidence.

I confirm the identity of the named retiree/beneficiary, account number and type. As representative of the above named Financial Institution, I certify that the Financial Institution agrees to receive and deposit identified payment in accordance with the **MASTER AGREEMENT** and agree that pursuant to Section 4.8.5 of the 2006 Operating Rules of the National Automated Clearing House Association the **MASTER AGREEMENT** is applicable to all payments sent by the RSA to the Financial Institution for benefit of the retiree/beneficiary.

Name of Representative _____

Signature of Representative _____ Date _____

Telephone Number _____

Note: Direct Deposit Authorization forms that are processed after the 14th of each month will become effective the following month.

Please return completed form to:

The Retirement Systems of Alabama
P.O. Box 302150
Montgomery, Alabama 36130-2150